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## ORIGINAL DEPARTMENT.

### COMMUNICATIONS.

#### TUBERCULAR LARYNGITIS, LARYNGEAL PHTHISIS, OR THROAT CONSUMPTION.

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[We have been favored, by Mr. Lennox Browne, with the following communication, which is chiefly drawn from one of the chapters of his work, in process of preparation, on Diseases of the Throat.]

That evidence of the tuberculous diathesis influences a local laryngeal inflammation in a manner eminently characteristic, and at a period long prior to the discovery of equally well-marked symptoms in the lungs, is a fact which the daily observation of those engaged in laryngeal practice establishes as incontrovertible.

Whether or not there be tubercle actually developed in the larynx, or what, indeed, is the nature of tubercle wherever developed, the author does not presume, and, indeed, does not care, to decide. Seeing, however, that tuberculosis is a disease primarily manifesting itself more especially in the respiratory organs; seeing that catarrh is one of the most frequent excitants to that disease, and that many catarrhal inflammations of the lungs commence in the larynx, it is at least fair to infer that, in those cases in which the eye reveals what has

come to be recognized as tuberculous laryngitis before the ear detects the presence of tubercle in the lungs, the disease has primarily attacked the former organ. Not only so, but noting also that the morbid changes in the larynx, as physically evidenced in every stage, are quite different from those of simple catarrhal, and of syphilitic, to say nothing of exanthematous and other phlegmonous inflammations, it is not unreasonable to suggest that the factors are also of an equally distinctive character.

It is quite certain that the pale, opaque tumefaction of the arytenoid cartilages and of the epiglottis in laryngeal phthisis, has not the clear transparency of serous oedema, the active glandular inflammation of simple laryngitis, the hyperplastic infiltration of syphilis, or the angry, inflammatory irritation of carcinoma. Nor is the consequent ulcerative process less distinctive; there is not erosion, nor deep excavated circumscribed ulcers, followed by narrowing cicatrices; nor new formations taking on an ulcerative process, but a true carious degeneration, causing loss of tissue, which, commencing superficially at small points, leads to universal destruction of the deeper parts, without extension to neighboring glands, and with but feeble, if any, attempt, under treatment, at a reparative process.

It is, therefore, surprising that we should be told, with reference to laryngeal phthisis, on the one hand, that "tubercle appears to play a very secondary part, if any part at all," in its production (Mackenzie); and on the other, "that neither the catarrh nor the ulceration of phthisical subjects presents any characteristic signs by which it could be recognized as such,

[and that] the attempts made to establish pathognomonic peculiarities cannot be said to have succeeded" (Von Ziemssen).

We prefer to adopt the view of Virchow, who just exactly recommends the larynx as the most appropriate place for the study of true tubercle.

**ETIOLOGY.**—The predisposing causes are, of course, those which are found to obtain in the production of tubercle generally; those exposed to catarrhal influences being more liable to have the larynx primarily attacked; while experience does not seem to prove that functional activity is a strong predisponent. On the other hand, debility of the general system, especially if resulting from amenorrhœa or other uterine disturbance, which leads to the production of the so-called functional or nervous aphonia, is a not uncommon premonitor of throat consumption. In such a case there will appear no disease in the larynx beyond a loss of adductive power in the vocal cords, and some paleness of the mucous membrane, explained by the general condition; and the lungs, although insufficiently expanded, and of somewhat diminished resonance, may be pronounced free from disease. Local treatment of the larynx by stimulating inhalations and by faradization may restore the voice, which is, however, soon lost again. Tonics, change of air and scene, are of no avail, and at a period varying from a few months to, perhaps, a couple of years, undoubted phthisical symptoms develop themselves.

Dr. Sawyer, of Birmingham, in an admirable clinical lecture on phthisical laryngitis (*Lancet*, January 30th, 1875), has done well in dividing the changes of this disease into four stages: 1. The stage of anæmia. 2. That of tumefaction. 3. That of ulceration. 4. That in which necrosis or caries of the cartilages may arise; and this division will be here adopted.

In enumerating the signs of laryngeal phthisis, it has been thought well to consider them independently of concurrent or pre-existent lung mischief; but, of course, in those cases in which pulmonary disease is advanced before there is any evidence of laryngeal complication, the character of the throat symptoms may be considerably modified.

**SYMPTOMS.**—(a) *Functional—Voice.*—Failure of the voice is a very early symptom. As just remarked, this may be due either to local lesion or to insufficient motor power of diseased

lungs; it may be quite early aphonic; more commonly; however, it is affected just in proportion to the amount of the local lesion; and the ordinary vocal symptoms of congestion, thickening or ulceration, already described at length when considering other forms of laryngitis, are witnessed.

There, is, however, a peculiarity in the voice of consumptives with laryngeal mischief, not generally noticed; this is found in the rapidity with which the voice changes in character during a quite short conversation, from a gruff hoarseness to a high falsetto, which as quickly passes into a toneless whisper. These changes are probably influenced by lodgment and dislodgment of secretion, and also by nerve-irritation. A somewhat similar, though to the practiced ear, distinct condition, is sometimes noticed in patients with laryngeal growths, variation in situation of which produces quick alterations in voice.

**Respiration**, although short, is not, as a rule, embarrassed in the early stage, but as tumefaction leads to mechanical loss of mobility, and the vocal cords themselves become thickened and ulcerated, extreme dyspnœa, with stridor and paroxysmal aggravations, may ensue.

**Cough** is naturally a prominent, and, on many accounts, a very distressing symptom in the advanced stages, whether it be due to local or to pulmonary causes, since the mechanical irritation in the larynx produces most acute pain, and the cough paroxysms are followed by extreme prostration. At a very early period the feeling of a desire to clear the throat of a foreign body predisposes to a worrying, unproductive cough. Expectoration is not copious, nor more than glairy in character, until suppuration is established. Hemorrhages from the larynx are but rare, even when there is advanced necrosis, and it is very difficult, even when suspected, to decide that the bleeding has originated in that region. Occasionally, however, the spot at which the vessel has given way can be seen. In one instance, a recent clot was observed on the vocal cord after a very moderate hæmoptysis, in which there was but slight corroborative local evidence of laryngeal tuberculosis, nor would the result of stethoscopic examination have been sufficient to justify the grave prognosis suggested by the laryngeal appearance, and, unfortunately, verified by the subsequent history of the case.

**Deglutition.**—Difficulty of swallowing is by

no means an invariable accompaniment of laryngeal phthisis, but when present it is, without doubt, the symptom which most tends to hurry on the fatal termination, and is the one on which account patients most frequently seek relief of the throat specialist. The trouble is partly mechanical, from impediment to the mobility of the epiglottis, which causes fluids to pass downward into the larynx, and backward into the naso-pharynx. Dysphagia is first experienced only in taking fluids, but as soon as there is ulceration, attempts at the deglutition of solids, unless first artificially masticated and made bland, cause the act to be acutely painful. This symptom of pain during the exercise of function is of great diagnostic value when there is the least idea that the disease may be syphilitic.

When, however, the parts can be kept at rest from cough, or when the patient is not eating, it is surprising how little local pain is felt; here, again, differentiating this disease from carcinoma.

(b) *Physical—Color.*—The first physical evidence of the laryngeal disease is a paleness of the mucous membrane; and it is something more than anæmia, for while all parts of the larynx, naturally pink, will assume a muddy and grayish hue, the vocal cords will often be found congested, and many engorged capillary vessels will be seen ramifying on that portion of the mucous membrane considered anæmic. As the stage of tumefaction arrives, the color, while it does not become less pale, is decidedly more opaque, except on the epiglottis, which, as it becomes thickened, loses its natural buff hue, and assumes a pale rosy tint.

Ulceration, except on the epiglottis and vocal cords, is not preceded by hyperæmia, but when the ulcers are formed there is often a faint red line at their circumference. The surface of the vocal cords, where loss of tissue has taken place, is frequently of a grayish-white or pale yellow color, while the rest of the cord is congested. The ulceration of the vocal cord is seldom deep; but cases have been reported in which it has extended to the arytenoid cartilage, leading to caries and extrusion.

*Form and Texture.*—Thickening caused by infiltration of the sub-mucous tissue characterizes the second stage of laryngeal phthisis. The part first affected may be one or both vocal cords; but much more commonly the first symptom is evidence of deposit in the inter-

arytenoid space. Then the well-known and often-described swelling of the arytenoid cartilages is seen, giving rise to the appearance of two pear-shaped bodies, the larger ends of which meet in the centre line, and consist of the swollen and no longer distinguishable cartilages of Wrisberg and of Santorini, tapering off, more or less, in proportion to the swelling of the ary-epiglottic folds, until they join the epiglottis.

Equally unrecognizable is the condition of the last-named part, which becomes so misshapen that no longer is its free edge, superior or inferior surface, or any ligamentous fold, to be distinguished, the whole being swollen into a horse-shoe or turban-like shape, which lies nearly horizontally at the base of the tongue, or is so flexed on itself as to resemble a lateral view of the index finger in a similar position.

Some allusion has been made to the character of the ulcerations: their peculiarity is their worm-eaten, carious appearance, showing that degeneration has not commenced at the surface, but in the deeper tissues, or rather, as is probably the case, that the secretion of the racemose glands has undergone degeneration; the glands have swollen, and have given way at the point most favorable for exit of the retained matter, namely, at the surface. These small ulcers then unite by breaking down of intervening tissue, and so form large ulcerating surfaces. Narrowing of the glottis is often the result of tissue changes, but there is never any attempt at cicatrization. Paralysis of one or both vocal cords is frequently seen, and may be due either to mechanical impediment or to nerve-pressure. Mandl and others have drawn attention to the fact that, contrary to experience in other paralyses of the recurrent laryngeal nerve, the right nerve is much more frequently pressed upon than the left, in cases of laryngeal phthisis. This is explained by the anatomical relation of the right nerve to the apex of the lung.

*Secretion.*—As mentioned when treating of the sputa, under cough, the secretion is altered in character from a glairy, viscid exudation of moderate amount, to a copious muco-purulent discharge.

Whenever there is actual chondrial caries, the odor is very characteristic, though fetor of the discharge may be also due to pulmonary causes.

If doubt exists as to the diagnosis, the secre-

tion may be examined by the method proposed by Dr. Fenwick, of boiling with a solution of potash, to destroy the mucous elements, and submitting the deposit to microscopic investigation. In such a case elastic lung tissue will often be seen at a period prior to the existence of well-marked auscultatory signs.

(c) *Miscellaneous*.—There can be no reason for entering largely into these symptoms, except to remark that increased frequency of the pulse and range of body temperature, as well as evidence of mal-assimilation, giving rise to dyspepsia and loss of weight, are of as great importance in the early stages of laryngeal as of general phthisis. With reference to the state of the lungs, early and frequently-repeated auscultations should be made. At first there may be nothing more than slightly diminished resonance, hardly perceptible increase of vocal fremitus, and prolongation of expiratory murmur; but gradually and surely the chest evidences will become more strongly marked. It must be remembered that though tubercular disease may be first detected in the larynx, no case has yet been reported in which a patient has died of that disease without well-marked symptoms in life, and appearance after death, of pulmonic disintegration.

*Treatment—General*.—This need scarcely be here entered upon at any length, as it must differ in no essential respect from that necessary for phthisis and tuberculosis generally, however and wherever manifested.

The indications for general treatment in regard to the local trouble are to diminish the cough, so as to give as complete functional rest as possible, and also to endeavor by internal remedies to relieve the irritability of the upper portion of the gullet. For this latter purpose bismuth and bromide of potassium, taken shortly before food, will often be found of great service.

The hypophosphites of soda and lime have certainly acted well in the author's practice, in those cases in which the evidence of the disease was primarily in the larynx, in checking night perspirations, diminishing cough, aiding digestion, and arresting loss of tissue.

*Local*.—In respect to local treatment, it is gratifying to know that many authorities eminent in the general treatment of phthisis, Dr. O. J. B. Williams, for example, speak in high terms of the relief that may be given by local measures when the disease attacks the

larynx; and yet many general physicians do not quite fully acknowledge how much success depends on careful attention to detail.

A proper inhaler, generating steam at a temperature accurately registered according to the special circumstances of the patient and the time of the year, so that while moist, warm air is inhaled, and the volatile ingredient thrown off, the respiratory muscles are not fatigued nor the circulation quickened, is surely better than a jug of hot water with a napkin lying over the patient's face and covering the jug; and it is not surprising if in the latter instance there is a strong liability to induce perspiration. Again, when remedies are applied they are often worse than useless, unless the mirror guide the hand, and the application be made to the part affected, and to that only.

Of inhalations, in the anæmic stage, and when the thickening is only commencing, stimulating volatile ingredients, as creasote, the oil of pine, and some essential oils, in water at a temperature of 130° to 150° Fahr., are of service; but when cough, distress of breathing, and dysphagia, due to narrowing of the larynx, ulceration of the cords, or of the epiglottis, occur, all inhalations must be of the most soothing nature.

Plain steam of water, at from 120° to 135° Fahr., compound tincture of benzoin, one fluid drachm to a pint of water, with or without from three to five drops of chloroform, for each inhalation, conium or hops, are to be recommended.

With respect to the last-named remedy, it should be remembered that the oil of hop is very stimulating, not to say irritating; while the extract, with a little carbonate of soda, as used with the extract of conium, or a fresh infusion, is most soothing.

Spray inhalations are of but little use in laryngeal phthisis; they, as a rule, involve great fatigue, and are peculiarly irritating to the mucous membrane, which, in this disease, is more than usually sensitive. The use of iodine in the form of inhalation is also to be deprecated, on account of its powerfully irritant properties.

Scarification is of most doubtful propriety in this disease: the wounds would invariably ulcerate, and the operation would certainly, looking at the very solid nature of the thickening, give but a minimum of relief.



Still greater local benefit may be found in the use of the brush than by inhaling; and here again it is encouraging to find Dr. Williams agreeing in condemnation of nitrate of silver. The most comforting solution is that of chloride of zinc, ten to twenty grains to an ounce of water, with, perhaps, a little glycerine. Oil is unadvisable, as preventing the absorption of the substance employed, and pure undiluted glycerine has the property rather of irritating than of soothing. This latter fact is worthy of note here, although it has been mentioned before, as practitioners largely employ the glycerine of tannin of the *Pharmacopœia*; and they would find it very much more serviceable if diluted with at least an equal quantity of water.

Bismuth, gum, and morphia is an application of much value for relieving the irritation of swallowing, and it may be administered in powder by insufflation, forming an exception to the general condemnation of this method of administering remedies, though it will be preferable, even in this case, for the practitioner to apply it in the semi-liquid form with the brush.

Lozenges containing morphia or opium are of the greatest value in relieving the cough, but it must be remembered, in regard to them, how small an amount of opium, taken in a lozenge, or of morphia, frequently repeated, will have the desired effect.

All food should be of the blandest character, and should be taken at a most moderate temperature. It will often be prevented from "going the wrong way," if the patient be directed to thicken his drink, and to gulp instead of sipping it. A raw egg swallowed whole, like an oyster, will be found both agreeable and nutritious in this disease.

The operation of tracheotomy was not unfrequently performed, in pre-laryngoscopic times, on patients who were the subjects of laryngeal phthisis. For this there was the excuse of ignorance of the actual local condition; but the same measure has even been adopted by practitioners who, using the laryngoscope, should have been aware of the futility of such a procedure. It should be borne in mind that in this disease the whole mucous membrane is most sensitive to irritation, and is strongly disposed to ulceration, and that the cartilages of the larynx and trachea are, if not actually degenerated, most prone, with the least aggrava-

tion, to caries. It is, therefore, extremely doubtful whether presence of a tracheotomy tube does not, in such a case, actually increase the embarrassment of both respiration and deglutition. At the most, it can but prolong life a few days or weeks, with but little, if any, amelioration of distressing symptoms. It therefore behooves the surgeon, when such a question arises, to thoroughly explain these facts to the patient, or to his nearest relatives, and to refrain from urging or even recommending operative measures.

## HOSPITAL REPORTS.

### PENNSYLVANIA HOSPITAL.

CLINIC OF PROF. DACOSTA, JAN. 5th, 1878.

Stenographically Reported for the MEDICAL AND SURGICAL REPORTER.

#### Catarrhal Pneumonia, Pneumonic Phthisis and Pulmonary Consumption—Differential Diagnosis and Clinical History—Treatment of Night Sweats and Symptomatic Fever.

GENTLEMEN:—I shall call your attention, this morning, to several forms of pulmonary disease, and in connection therewith will bring before you three cases, each of which illustrates a different affection of the lungs. The patient entering the room, whose condition we will first consider, is named Patrick G., a sailor, thirty-one years of age; he was admitted into the ward December 9th, 1877. In the clinical notes we find that the patient's father died with a cough, and hence a tendency to pulmonary disease may have been inherited. But we also learn that our subject was in good health until six years ago, although his habits were bad, and he had been intemperate. On one occasion, after sleeping on the grass in Central Park, in New York, he had a severe attack of pain in the right side, fever, and cough, which kept him in bed ten days or longer. Since then he has been subject to cough, which is aggravated in winter, accompanied by free mucous expectoration, sometimes blood-streaked. In truth, he had a small hemorrhage from the lungs one year ago, but never on any other occasion. He has lost flesh, especially recently, and occasionally he has sweating at night. He is weak, anæmic, and complains of cough and pain in the left side of the chest.

Here, then, we have an acute beginning to what is subsequently a chronic affection. He thinks it commenced six years ago, and he has never been free from cough since that period; one year ago there was a hemorrhage, slight in amount, but none since. He now has mucous expectoration, sometimes blood-streaked, and occasional pain in the side. We also observe, as an important sign of disease, that he has

been losing in weight, but not for any great length of time; only for one year has he had this symptom.

We found, upon examining him, that he had a temperature of 102° in the axilla. Auscultation revealed harsh breathing, with crackling at the apex of the left lung; and, moreover, it was evident that throughout the right lung marked disease existed, as shown by the generally diffused rales and uniform dullness, except at the apex, where signs of a cavity were detected.

I will now examine him in your presence, and determine whether the disease is still advancing. The temperature, as shown by the daily record, has now become reduced to the normal standard. Percussing the chest, I find that dullness on the right side is now less marked than before, but upon applying the stethoscope, the coarse rattling at the apex, and harsh breathing, with fine, subcrepitant rales below, are still audible. There is also crackling at the lower part of the right lung posteriorly. Harsh respiration is still heard at the left apex, both anteriorly and posteriorly. Therefore, the physical signs have not materially varied from those I have described to you. We can only say that they are stationary, and that with this condition the temperature has declined to the normal. Before dismissing the patient I will also call your attention to the clubbing of the finger nails, which exists here to a marked degree; and still further to the reddish-blue line on the gums, forming the so-called gingival line, both of which belong to the later stages of phthisis.

Now, there can be no doubt that, as this case stands, it is a case of tubercular disease. There can, also, be no doubt that it is temporarily arrested. This happy result has been brought about by cod liver oil, inhalations of carbolic acid, with good diet, and small doses of iodide of iron. In addition to what has been offered in evidence of his improved condition, I may state that, in the short time he has been under treatment, he has gained several pounds in weight.

This case involves one or two points worthy of discussion. The existence of extensive pulmonary disease does not admit of a doubt, nor does it admit of doubt that the gravity of the symptoms, with the physical signs of a cavity in the chest, and the pulmonary consolidation, have sensibly ameliorated. Moreover, in looking over the history of the case, it is also not a subject of doubt, that the affection has been of slow development, nor that it had an acute beginning in a cold, which this man, who led the life of a vagrant and slept anywhere, caught on one of his outings. He originally had a pulmonary difficulty, probably pneumonia of the right lung. Then his health began to fail, and less than a year ago he had hemorrhage. Be it remembered that previously he had been in good health.

Now, what has taken place? At first there was an inflammatory deposit in the pulmo-

nary cells, which was imperfectly absorbed. This remaining in the lung, permanently impaired its nutrition, keeping up irritation and inflammation, and finally leading to breaking down of the lung structure. This condition has been followed by tubercular deposit, not only in the lung originally affected, but also in the upper part of the left lung. The disease began in catarrhal pneumonia, subsequently terminating in tubercular disease. At the first a catarrhal pneumonia, now pneumonic phthisis, if you choose; and no longer confined to the right chest, but the left side is also invaded.

Several considerations deserve attention in the case before you. First, a better result would probably have been attained had the case been early attended to; the catarrhal pneumonia might have been arrested and the subsequent deposit prevented from taking place.

You may ask, at what period did this change happen? I think it occurred at the time of the hemorrhage, for you will notice that since that time he has been losing flesh.

In a case where you have reason to believe there is pneumonic disease, if you find loss of flesh rapidly becoming a marked symptom, co-existing with an increase in the bodily temperature, and spitting of blood takes place, you are justified in supposing that tubercular affection has been superadded to the original trouble.

The marked improvement here has been produced by cod-liver oil, iodide of iron, inhalations by the atomizer, and a generous diet, as you have heard detailed, and it forms an illustration of the temporary improvement we so often see in our cases after a short residence in the hospital, and, indeed, always look for when the temperature is stationary.

The next case well illustrates the truth of the remark just made. This man, Joseph P., twenty-two years of age, is a clerk, and has a wretched family history. His mother died of consumption, but he claims that he had no symptoms of chest trouble himself until he had a hemorrhage from the lungs, eighteen months ago. This bleeding came on without any evident cause, early in the morning, shortly after rising, and was profuse. He does not think that he had any cough before this hemorrhage occurred; in truth, he considered himself in perfect health at that time. Since the cough began he has had a succession of hemorrhages; indeed, it appears that during the succeeding three months he had as many as twenty-two in all. He has had no bleeding now for more than a year, but the cough persists, with occasional night sweats, progressive loss of strength and weight; indeed, he tells us that he has fallen away thirty-eight pounds since the disease began.

Here we have a history of a chronic cough preceded by a violent hemorrhage, in the person of a young man who was apparently in good health but who came from tubercular stock, and followed by all the evidences of tubercular disease. Nor is the evidence confined to the rational symptoms, for on examining him, we

find evidences of a small cavity at the extreme apex of the right lung. The temperature since admission has been as high as 103°, but lately, only occasionally has it reached 101°. It should be noted that neither in this nor the preceding case was there any albuminuria.

Not to occupy too much time with this patient, I will state that he was placed on cod-liver oil, half an ounce three times a day, as in the other patient, and he was given, as a tonic, eight grains of quinia, daily. His night sweats have been broken up by atropia. The dose given was one-sixtieth of a grain each night, and he has had no sweating since taking the first granule, of which he has used but three in all. He reported that the atropia stopped the sweating, relieved his cough, and made him more comfortable at night, but on the third morning his mouth was dry, and as he was otherwise better the atropia was discontinued. No inhalations have been used in this case. He has been in the hospital nearly four weeks, and has gained nine pounds in flesh, and the physical signs have remained stationary, the fever has declined. Like the preceding, this is a case of arrest of the morbid process for the time.

Now I will call your attention to a few points regarding the origin of this disease, and then to a few general considerations bearing upon this affection and its treatment. We find in this patient a history of hemorrhage first, and lung disease afterward. There is no history of catarrhal pneumonia here. It is a case of phthisis which has commenced apparently from a hemorrhage. The later writers called this phthisis from hemorrhage "*phthisis ex hemoptoe*," but modern physicians regard this origin only as an apparent exception to the rule, and that, in fact, the disease in the lung antedates the bleeding. And if these lungs had been examined, we would, I think, have found some evidences of disease, however slight, previous to the hemorrhage. But of late years another view has been offered by Niemeyer, who believes that blood effused in the lung structure may become such a source of irritation as to be followed by chronic inflammation and deposit. Now, what are my views on this subject?—you may reasonably ask of me, as your clinical teacher. I will grant, as a possibility, that a blood-effusion might lead to chronic pneumonia, and subsequent phthisis might be developed in some exceptional cases. I say, I am willing to state that this may occur, but most positively believe that the view that the hemorrhage arises from previous disease is, in the great majority of cases, true. Confirmation of this is found in the present case, in the fact that the patient comes from a tubercular family; and here also we find a sufficient cause for the whole trouble. I have not the slightest doubt but that previous disease of the lung existed. Why should this man have hemorrhages? No other interpretation than this can be given. A strain might lead to bleeding of the lung, but this would scarcely explain a succession of twenty-two hemorrhages in three months.

To sum up the points in this case of phthisis apparently arising from a hemorrhage, I have taken occasion to say that I regard this origin as only apparent, and that changes in the lung antedated the hemorrhage. Now you may want to know something of the principles of the treatment. I have told you that this man improved greatly on cod-liver oil and quinia, and that atropia relieved his night-sweats. The treatment of night-sweats by atropia originated in this hospital. We were the first to use it for this purpose, and it has since been generally adopted. We found that from one-sixtieth to one-eightieth of a grain, at bedtime, generally suffices; after a few nights we usually find that we can stop the remedy, or only use it occasionally. Now there is an objection to the use of atropia, in the fact that its physiological effect is to produce dryness of the throat; but this may be overcome by various means. Lime, or lemon-juice, lemonade, slippery-elm infusion, or a little tea, may be sipped, to moisten the throat, as required. I have also considered whether some remedy might not be employed for this purpose, and for some time have been using the fluid extract of jaborandi. Although I am not prepared to make any authoritative statement on this point, I may say that I have, on more than one occasion, obtained good results by combining these drugs. A small quantity of the fluid extract (f.3ss to f.3j) given with the atropia, will not prevent the latter from checking the sweating, while it keeps the mouth moister. But irrespective of this inconvenience of dry mouth, atropia is very serviceable; it acts beneficially by stopping a drain, and improving the general condition, in which, however, it is aided by cod-liver oil.

In conclusion, I will show you a case that will also illustrate some interesting points. Henry M., thirty years of age, of Irish birth, caught cold last summer, while playing cricket, and has had more or less cough ever since. It is a noteworthy fact that this case also had an acute beginning. He states that with his cough he had mucous expectoration, but has never spit blood. He complained of some pain in the left shoulder-blade, when he first caught cold, and recently he had a little more pain than before. There is no history of lung disease in his family, and the patient always enjoyed vigorous health previous to the onset of his present malady.

We find this condition of things in the last few days: He had a rather high temperature, from 102° to 104° in the evenings, with a marked decline, nearly to the normal, in the mornings, therefore, considerable variation. He does not have the appearance of fever, and, in fact, on referring to his daily record, I find that the thermometer this morning only indicated 99°. His respirations are somewhat hurried, twenty-six to twenty-eight in the minute. Upon percussion I find nearly the whole of the right lung has its resonance impaired, both anteriorly and posteriorly, and on practicing what I call respiratory percussion, the patient holding

his breath, with the chest successively examined in extreme expansion and emptied, the difference between the two sides becomes more striking. The respiration is harsh at the upper part, and feeble below, and a number of crackling sounds and fine rales are perceived throughout the right lung. On the left side there is some harshness of murmur, but without dullness. There are heard, occasionally, fine rales in the left side posteriorly, more particularly about the middle of the lung. The patient has gained about three pounds since he came into the hospital, although he had been losing flesh rather rapidly before he entered the ward, December 25th, 1877.

Now, what is the nature of the case before us? There is dullness and harsh breathing over the whole of the right lung, and harsh respiration without dullness on the left side, coming on, after exposure, in a healthy man. This patient is now in the condition that the first case was five years ago. A latent, sub-acute attack of pneumonia comes on after exposure to cold, followed by consolidation of the lung. This case will represent that form of consolidation that we call catarrhal pneumonia, and which was formerly known as chronic pneumonia, in which the effused lymph and fibrin does not pursue the course of that thrown out in ordinary acute pneumonia, which may be absorbed and disappear in a few days, but it takes a much slower course, and may be complicated by softening, as you have already seen. The case is one of catarrhal pneumonia, on the very threshold of pneumonic phthisis. He may never have true tubercular disease of the lung, but unless we can stop it the lung will break down, or, as in the first case, the tubercular process will be superadded. But we do not despair of restoring him to health.

We have to deal with an irritative fever in these cases, as you observe in the high temperature. Now, let me, before discussing the treatment, say just one word in allusion to the temperature chart, where you notice the most extraordinary differences between observations taken in the morning and evening. Is this high temperature significant? Is there anything peculiar and characteristic in these excessive and sudden variations? In answering these queries, I will state that these marked differences of  $3^{\circ}$  or  $4^{\circ}$  between the morning and evening temperature is one of the characteristics of pneumonic phthisis. I have more than once been called in to attend a case of supposed malarial fever, which was really pneumonic phthisis. The temperature chart is, then, one important sign of the malady.

As regards the treatment, while we have marked high temperature and fever in the afternoon we must reduce it. The only two remedies that are truly worthy of our confidence for this purpose are quinia and digitalis; salicylic acid has been tried but has failed, ca bolic acid has been also used, with varying results. I will, therefore, give our patient two grains of quinia and one grain of pow-

dered digitalis, three times a day, of course carefully watching the action of the latter and discontinuing it when its specific effects are obtained. Where there is much cough a little opium may be added to this pill, with benefit. He shall also have a granule of atropia at night, to be stopped when the sweats are broken. Can we do nothing for the consolidation, in order to stop the breaking down of the lung? Certainly this requires serious attention, and the indication may be well met by giving small doses of iodide of potassium and muriate of ammonia, say three grains of the iodide to five of the muriate which may be dissolved in a tablespoonful of compound licorice mixture. This, it is hoped, will lead to absorption, aided by stimulating applications to the chest.

These cases illustrate, in a striking manner, some of the varieties of what is called pulmonary phthisis, and some of the principal modes of the origin of this disease, the elucidation of which is one of the greatest achievements of modern pathology, and one of the most satisfactory evidences of its progress.

#### MERCY HOSPITAL, CHICAGO, ILLINOIS.

CLINIC OF PROF. N. S. DAVIS, DEC. 20TH, 1877.

Reported for the MEDICAL AND SURGICAL REPORTER  
by R. M. LACKEY, M. D.

##### Lesion of Nerve Centres Following Concussion.

The case to which I will call your attention to-day is one of peculiar interest. Its history is as follows:—Joseph S., of St. Joseph, Mo., aged 41 years, by occupation a marble cutter. In November, 1873, he was struck with a stone on the frontal bone, just above the nasal process; he was rendered insensible for some hours, by the blow; there was a deep cut at the seat of injury, but no fracture of the bone. To all appearances he soon recovered from this injury and resumed his work as usual. In March, 1874, his left hand, where it came in contact with the marble while at his work, began to trouble him, and soon after he noticed that he was unable to control the motions of the left arm and the right leg; in consequence of this condition he had to stop work for four months, at the end of which time he had so far recovered that he again went to work. He states that he had electrical treatment during the time. In March, 1875, he was exposed to cold and had a relapse, the same parts being affected as before, and the same inability to control the movements of the right leg and left arm were present. He had also partial loss of sensation, and a cold feeling; could not walk without staggering, and soon became tired on attempting any exertion; had pain in the head, in the frontal region, as well as posteriorly at the base of the brain. These symptoms gradually increased in severity for a year, and during the past year he has not been able to get around. His vision began to fail in June, 1876, and continued failing, so that the past four months he has been entirely blind; the left eye began to fail



first. He has been under active treatment until about two months ago; since then has had no treatment, and claims that he has improved some since the treatment was discontinued. Thinks he can see a little now; can discern objects placed before his eyes, or passing between him and the light. His hearing is good, as is, also, smell and taste; has a little difficulty of swallowing; talks pretty well; tongue clean, appetite good, discharges normal. Is very forgetful, he states, but thinks he can indite a letter as well as ever, and keep a train of thought as well. He has a somewhat anæmic appearance, as you see, due largely to his long confinement. His condition resembles, in many respects, that which is present in locomotor ataxy, and he has at the same time some choreic symptoms; but his is not a clearly defined case of either locomotor ataxy or chorea; neither is it paralysis; for, as you see, he has motion, and when he gets hold of your hand he can squeeze it quite firmly. The peculiar feature in his case is the loss of co-ordinating power; when he attempts a movement, he fails to accomplish his purpose, on account of the loss of this power, and not from inability to move. His toes turn down, and the leg goes in the wrong direction in spite of him, and the whole body has a tendency to turn to the left side, and he feels like reeling.

Now, as to the seat of his disease: study carefully the order of events in his history, and I think we will be able to trace it to the under surface of the left anterior lobes of the cerebellum and cerebrum, near the tubercula quadragemina, whose fibres, passing down, furnish nerves to the left arm, and passing further down, and across to the opposite side, furnish nerve power to the right leg. The morbid action set up in a small spot by the concussion produced by the blow on the forehead has been gradually extending so as to involve the anterior lobe of the left cerebellum, and across to the right side, and to the origin of the optic nerves as well. What relation has the blow to this disease? It is the nature of blows which produce concussion to partially, or apparently wholly recover at first, yet the molecules of the brain substance have been so disordered as to impair the vitality and nutrition of the part, and a slow and gradual change goes on, in which the brain matter is eventually deficient and connective tissue takes its place; and there is, then, what we have in this case, that pathological state known as sclerosis.

The direct force in this instance did not produce fracture, but the counter-force was sufficient to produce injury elsewhere, which has resulted in a morbid process, and may involve a low degree of inflammatory action, which will account for the pain he has had in the head.

The all-important question to the patient is, can he be helped, or must the disease go on until the more essential parts of the brain structure become affected? In most cases this is the result. They sometimes come to a stand-

still for a time, and the disease may seem to be arrested, but the termination is eventually unfavorable.

As one means of relief, it is desirable to secure rest; both body and mind must be set at rest; his coördinating powers must not be taxed. He may move moderately, turn in bed, and move the limbs, and flex and extend them, so as to prevent stiffness, and keep up the power of the will over them as fully as possible. His diet must be nutritious but not stimulating; he may use weak tea and coffee. As to medicines, during the stage of pain and fullness of the blood-vessels, give iodine and mercurial alteratives, as the iodide of soda and bichloride of mercury, with conium. After this stage is past these remedies are not advisable, but we must promote nerve nutrition with the phosphates. I will direct him to have at meals the compound syrup of hypophosphites and extract of malt. We would not venture now to give him strychnia or use electrical currents, for fear of stirring up too much action, and bringing on his old headaches. After continuing the more soothing remedies for awhile, we may cautiously resort to the last-mentioned remedies with advantage.

## MEDICAL SOCIETIES.

### PHILADELPHIA COUNTY MEDICAL SOCIETY.

FRANK WOODBURY, M.D., REPORTING SECRETARY.

Conversational meeting, held November 14th, 1877, at the Hall of the College of Physicians, Professor Henry H. Smith, President of the Society, in the chair.

A vote of thanks was tendered Dr. J. A. McFerran, for his paper, entitled, "Is there Not an Element Wanting in the Construction of the Obstetric Forceps?"\* accompanied by a pair of forceps of novel construction, which he exhibited to the Society.

Dr. A. H. Smith praised the ingenuity displayed in the construction of the forceps exhibited by Dr. McFerran. He could not, however, altogether agree with the lecturer, in the statement that the use of the ordinary forceps necessarily precluded the possibility of the head following its natural course through the canal, nor in the assertion that the condition of affairs after applying the forceps is just the same as if the child's cervical vertebræ were ankylosed. Nor can the statement be accepted without question, that everything depends upon the individual skill of the operator, and that all the different instruments can be made to produce equally favorable results. We expect to accomplish more with our light forceps than would be possible with the heavy English ones, and undoubtedly can and do have better success.

\* See page 421, vol. xxxvii.

With the forceps of the ordinary pattern we can do all that can be done by those with the hinged blades. Moreover, that the hinges are a positive objection, in so far as they weaken the strength of the instrument. In the fixed forceps we know, by means of the direction taken by the handles, the exact position occupied by the head at any stage of its progress; this advantage is lost in a pair with movable blades.

In regard to the lateral or rocking motion that we are sometimes advised to give to the handles, the truth was recently enunciated by Matthews Duncan, which Dr. Smith has for fourteen years taught his classes, and he therefore quite agreed with the lecturer, that no force should be expended in lateral motion.

The handles of the forceps are often improperly used for the purpose of making sustained and powerful traction. This is wrong; they should not be used to pull with, but to guide. The advice of authorities, to brace the knees against the bed, or person of the patient, in order to pull, should be positively disregarded, and cannot be too strongly deprecated. The instruments should be used to guide the head according to the course properly adopted by it in the natural mechanism of labor.

I believe that with the old Davis forceps, introduced into this country by the late Prof. Meigs, we can deliver any child that it is possible for any forceps to deliver living. With an instrument of this kind, whose blades are applied fairly to the sides of the child's head, we have full control of the head; there is a powerful grasp, without powerful compression.

The Hodge forceps comes next to the Davis, in my estimation, but I think they are more liable to slip. In using the short forceps they are to be applied as nearly laterally to the head as possible; the simple traction should be made in the line in which you wish the head to be carried. The great mistake in the construction of the ordinary forceps is that they are made with long handles and immense hooks or rings, as if strong pulling were to be employed; the temptation is to lay hold of these powerful instruments, and do great mischief to the patient.

In spite of the opinion expressed in the paper of the evening, I claim that these (Davis) forceps will lay hold of and deliver a child's head from above the superior strait, the handles accommodating themselves to the position, and going to one side or the other in the sacro-sciatic notch.

In the use of the forceps we should simply follow nature's indications, and allow flexion and rotation to take place; at least, we must not attempt to interfere with the normal mechanism of labor, which, indeed, often occurs in spite of the forceps, rotation, extension, and flexion taking place independently of the instrument, by the force of nature.

The forceps exhibited are entirely different from those of Tarnier, which instrument has

two sets of handles, one fixed and the other movable on a joint.

Dr. William Goodell formerly believed with Dr. Smith, but of late years has been led to think differently, as he had expressed himself in a paper read before the International Medical Congress.

The forceps shown are entirely different from Tarnier's, and display much originality. The idea is a good one, but he thought that a little lateral motion would be an improvement.

In a case where he applied the ordinary forceps and found they would not work, he removed them and brought the head around the promontory by the aid of the vectis, and then re-applied his forceps and effected delivery without further trouble.

Dr. MacFerran thought that the principles involved in the hinged forceps appealed to the reason and the judgment, and was willing and anxious that they should have the test of experience. All the writers, from Baudelocque down, say that it is impossible to make traction in the direction of the axis of the superior strait, with the ordinary straight-handled forceps. The forceps recommended by Dr. Smith, applied at the superior strait, bring the head down obliquely, which is of great importance in a close pelvis, where there is but little difference between the diameters of the child's head and the maternal pelvis. This difficulty is met by the hinged blades in a manner that was utterly impossible to be done by any other forceps that he had ever examined.

#### Compound Useful in the Treatment of Asthma.

Dr. Wm. M. Welch called the attention of the members to a substance that he had found to be useful in the treatment of asthma. It was a powder, to be burned in the sleeping-chamber, and the fumes inhaled. It was composed of two and one-half parts of nitrate of potassium, one-half of a part of belladonna, and five of powdered stramonium leaves, intimately mixed with a small proportion, say, one-half part of pulverized white sugar, the latter being added to prevent the compound from burning too freely. The saltpetre may be dissolved in just enough water to make a saturated solution, which is mixed with the leaves and subsequently the mass dried into a coarse powder, and sugar added. A small quantity is placed on a brick or tin-plate and ignited, when it burns, giving off a cloud of smoke. He had, occasionally, spread sheets over a clothes-horse, for the purpose of confining the fumes, and had obtained very satisfactory results during paroxysms of asthma.

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—The total amount of opium imported into the United States for 1877 was 2,589,924,383 grains. Deducting one-fifth for medical uses, there remain for opium eaters 6,125,383 grains daily. If thirty grains are taken as a daily dose, there are in the United States over 200,000 men who eat opium.

## EDITORIAL DEPARTMENT.

## PERISCOPE.

## The Orthomorphie Treatment of Deformities.

This is the name which Dr. Dally, of Paris, gives to his method. It is described as follows by the correspondent of the *British Medical Journal*:—

He professes to cure without the aid of mechanical apparatus or cutting instruments. Dr. Dally's method of treatment consists of various manipulations, exercise, passive or active, hydrotherapy, electricity, regulated diet, etc., for carrying out which he has founded an establishment of his own in Paris. The principles of his treatment are, that these agents, being powerful modifiers of the tissues, the secretions, and organic or structural forms, in a determinate direction, may be applied to deformities with greater chances of a permanent cure than by mechanical means, or even with the knife. The tendency of the body or parts of the body to assume certain attitudes by practice or training may be seen by what may be effected with animals and human beings that are exhibited in public places, such as pugilists, acrobats, and horrible "dislocators," from whom some hints may be taken for the fulfillment of certain indications in the treatment of deformities. I have paid a visit to Dr. Dally's establishment, and was much pleased with the internal arrangements of the place. I cannot say it is vast, but it contains all the requisites for carrying out the different methods of treatment referred to above. Beside deformities of the body, other affections, such as gout, rheumatism, etc., are here treated on the same principles, and I know of a case of alcoholism that was thoroughly cured in less than two months by "massage," electricity (continuous current), and "sudation." The patient was a major of the Indian army, who was obliged to leave, as he felt himself utterly incapable of performing his duties. Under the impression that spirits were necessary for his health, he used to take a glass of brandy the first thing in the morning. This was gradually increased and repeated several times, till he reached half a bottle a day, independent of the beer and wine he took at meals. He used to say he drank this quantity, not from thirst or pleasure, but he felt that it was a want that he must satisfy. He left India on furlough, to go to Europe, about the beginning of the year, and on his arrival at Paris placed himself, through the advice of an English physician, in the hands of Dr. Dally. Dr. Dally stopped his allowance of brandy at once, permitting him to have a pint of beer at each meal, and subjected him to the treatment mentioned above. Since leaving Dr. Dally's estab-

lishment, the major has twice written to say he still abstains from spirits; he never feels the want of them, and hopes that he is as thoroughly cured of the habit as he is of his illness.

## The Nervous Symptoms of Gout.

The following admirable summary of the nervous symptoms arising from gout are given in the *British Medical Journal*, by Dr. J. Russell Reynolds, the eminent Professor of Practice in the University of London:—

I. *Mental Disturbances*.—Many cases have come before me in which there was great restlessness; the patient could not be still for a moment; was alternately excited and depressed; slept badly, or not at all; was intensely hysterical; and could not attend to business; while others have complained of failing memory; of want of power of attention; of suicidal thoughts; of intense melancholy; others of sounds in the ears; voices, sometimes distinct, sometimes not; and some or all of these of long continuance; but yet all disappearing under treatment upon the hypothesis I have mentioned. These symptoms often alternate with, or accompany, those which I mention next.

II. *Pain in the Head*.—Some of the most intense head pain that I have met with has been of this character, and been relieved by treatment of an anti-gouty description. The special features are pain on one side of the head, usually parietal or occipital; "grinding" habitually; but forced into almost intolerable severity by movement, such as the jar of carriage riding, or running down the stairs of a house; and this without any over-sensitive nerve points; without tenderness of scalp; and without any aggravation by mental exertion. It is not affected by posture or by food; it is relieved by physical rest, and may disappear entirely after treatment of the kind that I have mentioned. It is not anæmic, nor neuralgic, nor dyspeptic (in the ordinary sense of that word), and it yields to nothing in the way of treatment that may be directed against those common varieties of headaches. It is very often associated with some of the other symptoms that I have mentioned, and they must be taken into account when making a diagnosis of the malady.

III. *Modified Sensations*.—1. Of these, vertigo is one of the most common, and it may exist alone. It takes, sometimes, the form of objective movement, but more frequently that of subjective movement, such as the sense of "swimming" or "floating" away. This vertiginous sensation is sometimes determined by posture, and occurs only when the patient lies on one side, it may be the left or the right, the apparent movement of external objects being from that side toward the other.

2. With vertigo is often associated "noise in the ears," not the sound of "voices," but drumming, hissing, singing sounds, recognized to be in the ears, or in one ear, or in the head, and not appearing to come from outside. There is not, or need not be, any mental delusion with regard to these; the patient knowing well that they are inside his organism.

3. Associated with such vertigo and tinnitus there is frequently deafness, and the feeling of "beating in the ear;" and the symptoms are like those described by Meniere; but I have found them in the vast majority of instances associated with a gouty habit. With vertigo and tinnitus there may be much mental depression, or attacks of bewilderment, amounting sometimes to those of *le petit mal*.

4. Modified sensations in the limbs may occur. A large number of people complain of "numbness," "tingling," "creeping," "deadness," or some other altered state of sensibility in the limbs, which, sometimes taking a paralytic, sometimes a hemiplegic, distribution, have caused much anxiety; and the more so, because the suggestion of organic disease of brain or spinal cord has sometimes been conveyed, and yet all these troubles pass away. That which I have observed to be in them the most characteristic of their gouty origin is their variability in kind and locality. To-day, for example, there is "coldness" in the left leg; to-morrow, "a sense of heat;" last week, a "pricking" in the right hand; the week before, a "stinging" feeling on the side of the head, or in the tongue. This wide distribution and variability, so alarming to the patient, is much less alarming to the physician, who recognizes in these very facts the elements for a favorable prognosis.

Here, too, I must mention the great frequency with which pains, flying pains, darting pains, often like those of ataxia, are met with in the limbs. So-called "sciatica" is of frequent occurrence, and "pleurodynia," and "myodynia," of all localities, are common enough. The sciatica of gouty sort is often double, shifting from side to side with a frequency that does not improve the temper of the gouty patient, but may raise the hope of his physician as to the probability of cure. Other seats of pain are most frequently the insertion of the deltoid muscle and the inner aspect of the upper arm, the ankles, the heels, and the interscapular region. The lower mammary region on the left side is often the seat of pain, as it, indeed, is in many other maladies.

iv. *Modifications of Muscular Action*.—1. Cardiac palpitation, intermittence or irregularity of pulse, or painful aortic pulsation at and below the epigastrium, often suggest to the patient the presence of cardiac disease; and it is worthy of remark that, on the one hand, a very great amount of discomfort may often be felt by the patient when the physician can discover no change in sound of heart or rhythm of pulse; and that, on the other, disease of aortic valves, and other obvious signs of car-

diac change may often be discovered by the physician in a gouty patient, he having never been conscious of any thoracic trouble.

2. Flickering contractions of muscles in the limbs; tonic spasms, with cramp-like pains; and "startings" on falling asleep, have often appeared to me to be of gouty origin, and that for the reasons that I have assigned. Priapism, without erotic feeling, is also very common. It sometimes disturbs the sleep, is felt on awaking, but quickly disappears, without emission.

3. Local weakness of muscles, such as ptosis, single or double; want of co-ordination of movement of the limbs, both upper and lower, giving an awkwardness of movement and an ataxic gait—are among the symptoms that may have the course and history that I have suggested. I have recently seen several cases of ataxia, and one with marked double ptosis, which had been treated unsuccessfully upon a syphilitic hypothesis, but which recovered speedily when the treatment was based upon a gouty theory.

v. Lastly, there are symptoms beyond those which I have mentioned, and which do not form part of the matter for my description now, but which I will simply enumerate as being further guides or helps in the diagnosis of gouty cases: 1. Dyspepsia, cardialgia, distention of stomach and colon with flatus, pyrosis, and acid eructations. 2. Varicosity of veins, with tendency, upon slight injuries, to occlusion of veins. 3. Brittleness and vertical lining of the nails of both fingers and toes. 4. Slight conjunctivitis, with occasional chemosis.

The groups of symptoms that I have enumerated rather than described sometimes co-exist, sometimes alternate, and their phases are often very puzzling. They present great difficulties in diagnosis and in treatment until the clue is caught. It is often saddening to look through the carefully cherished prescriptions, and especially when they are one's own, and see the long array of drugs that have done no good—iodine, bromine, strychnine, quinine, zinc, iron, silver, cerium, arsenic, valerian, and hops, to say nothing of mercury, bitter infusions, mineral acids, and the like; but then one's sorrow may often be turned into joy—and a joy in which the patient most heartily participates, when a simple treatment, such as I have suggested, is adopted, and all the troubles disappear with a rapidity that seems quite magical, and reminds one of that beautiful process of clearing a photographic picture by cyanide of potassium.

#### The Varieties of Urethritis.

Before the Medical Society of Vienna, lately, Dr. Grünfeld gave an account of the results which he had obtained by endoscopic examination in cases of gonorrhoea in early stages. He made the following distinctions:—

1. *Urethritis blennorrhoeica* (acute blennor-



*rhœa*). The urethral mucous membrane is covered with pus, and appears in the endoscope in the form of distended semi-globular elevations, moderately reddened, and often bluish or dark red. Mechanical irritation of the mucous membrane readily produces bleeding. The usual situation of the disease is the anterior part of the urethra.

2. *Urethritis membranacea*. Here there is generally œdema of the prepuce, and the freshly passed urine usually contains fine leathery membranous masses. The endoscope shows that there is pus, but less than in the previous form; the mucous membrane is not red, but covered with an extensive layer of whitish-gray exudation, firmly adherent, and not removable without causing hemorrhage. After a few days the mass of exudation is thrown off, and the appearance of urethritis blennorrhœica is presented.

3. *Urethritis simplex*. In this, large masses of pus are formed, but the swelling of the mucous membrane and the hyperœmia are not so great as in the first form.

4. *Urethritis granulosa*. This form has been mostly described by Désormeaux. The mucous membrane is but little covered with pus, but is arranged in three folds of a somewhat dark red appearance, uneven, velvety, and here and there presenting punctiform elevations.

5. *Urethritis with ulceration*. To this class belongs herpetic urethritis, in which, at a distance of three fourths of an inch to an inch and a half from the orifice, are found small shallow ulcers, distinguishable only by their gray color from the surrounding reddened mucous membrane. This form of the malady is rare, and occurs only in persons who have herpes præputialis. Dr. Grünfeld only found chancrous ulcers at a small distance from the orifice; they presented the same appearance as on other mucous membranes. He had not been able to find catarrhal or tuberculous ulcers, or *plaques muqueuses*, in the urethra.

#### The Surgical Treatment of Empyema.

According to Mr. H. Marsh, of the Hospital for Sick Children, London, as given in the *British Medical Journal*, there are two proceedings connected with the treatment of empyema that are often found troublesome to carry out: the introduction of the drainage-tube, and the washing out of the cavity of the pleura. The usual method of introducing the drainage-tube is to make an opening in the fifth intercostal space; to pass a long probe through this, downward and backward, to one of the lower spaces; to make the point of the probe prominent beneath the skin, to cut down upon it, and then to drag the probe through the pleural cavity with the drainage-tube attached to it. The following appears to be a somewhat more simple and convenient method.

A number three catheter is threaded with a piece of strong ligature silk. This can be done by passing a piece of silver wire along the tube

of the catheter, from the eye to the handle end, and dragging the silk through with this. Two or three inches of the silk are left projecting from the eye and four or five inches from the opposite end. The catheter, thus prepared, is used instead of the long probe; it is introduced through the upper opening and passed to the lowest part of the pleural cavity; its point is rendered prominent in an intercostal space, an incision is made upon it, and it is brought out through the wound till the silk emerging from its eye can be seized; the silk is firmly held while the catheter is withdrawn, and then the drainage-tube is attached to the silk, and drawn through the chest from one opening to the other. The catheter is a convenient instrument for this operation; it is more rigid than an ordinary probe, its curve is appropriate, and its handle enables the operator to hold it firmly and to use it as a searcher for the lowest part of the pleural sac, while it obviates the necessity of dragging the probe through the chest.

Mr. Marsh has found the following plan useful for washing out the chest. If drainage have been previously used, a special tube is prepared, as follows. It is made of red india-rubber, which is tougher and much more durable than the vulcanite, and is not affected by any agent used for injecting the pleura. This tube should have holes cut in its side, only in the lower half. Three or four inches from its upper end a piece of silk should be tied around it, so as completely to close its canal at this point, and just above this constriction a fenestra should be cut in its side. To wash out the chest, all that will be now required is a piece of smaller tubing, one end of which is inserted into the upper end of the drainage-tube, and the other in the fluid which is to be injected, which is held in a vessel six or eight inches above the patient. The apparatus will act as a syphon. The fluid will pass through the smaller tube into the larger, which it will traverse till it reaches the constriction, where it will escape by the fenestra into the cavity of the chest, and will then run out either through the lower opening by the side of the tube or through the perforations in the tube itself. This plan can be carried out without pain or any disturbance of the patient.

## REVIEWS AND BOOK NOTICES.

### BOOK NOTICES.

**Prescription Writing: Designed for the Use of Medical Students who have Never Studied Latin.** By Frederic Henry Gerrish, M.D., Professor of Materia Medica and Therapeutics in the Medical School of Maine. Loring, Short & Harmon, Portland, Maine. 1 vol., cloth. 12mo, pp. 52.

The author of this work has prepared it in

the hope of bringing something like correctness into the Latinity of prescriptions. It is to be regretted that there are medical students who have never studied Latin. All such had better go to farming, or blacksmithing, or some other such occupation for which their education fits them. But as, unfortunately, there is no hope of this, they had better study the work before us, or else, what we should prefer, give up the absurd custom of trying to write a language of which they know nothing.

Dr. Gerrish gives the rules for the declensions of nouns, a list of the Latin words used in writing prescriptions, explains the signs, and adds a number of sensible hints on prescribing clearly and carefully. He is generally correct, but on page 36 his own Latin trips, where he closes a prescription with

Aquæ, ad. 3vj.

This should be *aquam*, the noun being the direct object of the verb *recipe*. Again, if the words *lagena* or *scatula* are at all in use now, in writing prescriptions, it must be in a limited territory. They are not given, for instance, in Beer's *Pharmaceutical Dictionary*.

**Cyclopædia of the Practice of Medicine.** Edited by Dr. H. Von Ziemssen. Vol. xvi. Diseases of the Locomotive Apparatus, and General Anomalies of Nutrition, by Professor H. Senator, of Berlin; Professor E. Leitz, of Giessen; Professor H. Immermann, of Basil; and Dr. Birch Hirschfeld, of Dressen. Albert H. Buch, M.D., New York, editor of American edition. William Wood & Co., New York.

The publishers announce that they find themselves obliged, very reluctantly, to extend the work to seventeen volumes, but that it is absolutely certain that seventeen volumes will complete the work.

Professor Senator writes upon the Diseases of the Locomotive Apparatus, and Diabetes Mellitus and Insipidus; Leitz, upon "Slight Disorders, caused by Catching Cold;" Immermann, upon "General Disorders of Nutrition," and Corpulence; Birch Hirschfeld, upon "Scrofulosis and Affections of the Lymphatic Glands in General."

Space will allow the mention of a few points of the work. The section on "How We Catch Cold," etc., is particularly interesting. The disorders belonging to this group are most common in wet, cold, and windy weather; while any one of the above factors acting alone,

e. g., severe cold, without rain or wind, a high wind at midsummer, etc., does not usually cause any ill effect. The old notion that these diseases are due to suppression of the cutaneous secretion is rejected. This chapter will repay a very careful perusal.

Under "Disorders of Nutrition," anæmia, chlorosis and pernicious anæmia, are considered. One hundred and thirty-one pages are required to consider corpulence, forty of which are devoted to its therapeutics. Prophylaxis is desirable, and, to a certain degree, successful. The indications for treatment are: 1. Diminution of the introduction of lipogenous material in the pabulum; 2. Increase of the trophic and plastic energy of the albuminized tissues of the body, especially those of the voluntary muscles; 3. Increase of the general stock of red blood-corpuscles, by promoting their new formation; 4. Increase of the animal process of oxidation, by increased introduction of oxygen. The work is bound and printed in the usual good style of the preceding numbers.

**Transactions of the Twenty-second Annual Session of the Michigan Dental Association**, held at Ann Arbor, October, 1877. Published by Ransom & Randolph, Toledo, Ohio. pp. 88.

This is the first time that this association has published its Transactions in volume form, and both the contents and appearance of the present issue are highly creditable to it. Of the original papers contained may be specified: On Tooth Bearing Tumors of the Jaw, by D. C. Haxhurst; On the Physiology of the Dental Pulp, by Professor J. A. Watling; On Dental Education, by T. K. Perry; On the Separation of Operative from Mechanical Dentistry, by several writers; On Dental Prosthesis, by C. B. Porter, etc.

**Pneumo-Dynamics.** By G. M. Garland, M.D. New York, Hurd & Houghton, pp. 155.

We have here a very careful experimental study of the problems of physics involved in the motions of the lungs, an effusion, and the thoracic walls. The conclusions which the author reaches differ considerably from those generally taught, and he supports them by numerous experiments and close reasoning. It is not practicable to give a synopsis of his doctrines in moderate limits without doing them injustice; and we would therefore refer the reader to the work itself, assuring him that he will find it highly creditable to the medical science of this country.

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D. G. BRINTON, M. D., EDITOR.

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PREMIUM LIST  
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The following premiums are offered to our subscribers as inducements for them to aid us in increasing our circulation:—

1. For one new subscriber to the REPORTER, we give a copy either of the *Physician's Pocket Record* (\$1.50), or of *Dobell on Coughs, Consumption and Diet* (\$2.00).

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In all cases the remittance for the new subscriber must cover one full year's subscription.

THE SURGEON GENERAL'S REPORT.

The Annual Report of the Surgeon General, U. S. A., has lain on our table longer than usual this year. Yet it is a document in which the whole medical profession is interested.

The total number of deaths reported, from all causes, among the white troops, was two hundred and sixty, or eleven per thousand of mean strength. Of these, one hundred and eighty, or eight per thousand of strength, died of disease, and eighty, or three per thousand of strength, of wounds, accidents and injuries.

The proportion of deaths, from all causes, to cases treated, was one to one hundred and fifty-five.

The total number of white soldiers reported to have been discharged the service, on "Surgeon's Certificate of Disability," was seven hundred and forty-seven, or thirty-two per thousand of mean strength.

Among the colored troops the total number of deaths reported, from all causes, was thirty-two, or fifteen per thousand of mean strength. Of these, fifteen, or seven per thousand of mean strength, died of disease, and seventeen, or eight per thousand, of wounds, accidents and injuries. The proportion of deaths, from all causes, to cases treated, was one to one hundred and thirty-six.

The total number of colored soldiers reported to have been discharged, on "Surgeon's Certificate of Disability," was fifty-eight, or twenty-eight per thousand of mean strength.

Yellow fever made its appearance in the city of Savannah, Georgia, during August, 1876, and prevailed for several months, causing eight hundred and seventy-six deaths among the citizens. Company D, 5th Artillery—forty-three officers and men—then stationed at Oglethorpe Barracks, was withdrawn August 29th, and went into camp at station Four-and-a-half on the Georgia Central Railroad (in Screven County), forty-six miles northwest from the city. This movement was successful in preserving it from the ravages of the epidemic.

But two cases, both of which terminated in recovery, are reported to have occurred in camp. On the other hand, a non-commissioned officer left on duty at the barracks, as well as a non-commissioned officer and a private soldier of the signal service, on duty in Savannah, were attacked by the fever, and all died. Also, a non-commissioned officer of the signal service, stationed on Tybee Island, at the mouth of the Savannah river, contracted the disease, probably, it is reported, by visiting the infected city, but fortunately recovered. The epidemic having subsided, the command returned to Oglethorpe Barracks, November 23d.

In the Record and Pension division there was a total of 33,347 official demands for information. So much was the office crippled by want of funds to employ the necessary clerical force to meet this enormous demand, that *not one-half* of these inquiries were answered. The Report justly says this condition of affairs is deplorable (we should say, most disgraceful to Congress). Poor and suffering families are left to languish year after year, by this misplaced economy.

About 1000 volumes and 2000 pamphlets were added to the library, and the subject catalogue has been proceeded with satisfactorily. The Surgeon General renews the recommendation made in his previous report, that Congress should authorize the printing of this catalogue by the Government Printer. Its preparation has required much labor, and of its utility to the medical profession, if made accessible to them, there can be no doubt. The expression of opinion by physicians of this and other countries is unanimous upon this point, and it is to be earnestly hoped Congress will not delay the appropriation.

The work of stereotyping the Medical volume of Part II of the Medical History of the War was commenced in January, 1877, Surgeon J. J. Woodward, the officer in charge of that work, having previously been occupied by his duties in connection with the Centennial Exhibition.

Between that time and July 30th three hundred and twenty-five pages were stereotyped, and it is confidently expected that the volume will be ready for issue before the close of the present fiscal year.

A second edition of five thousand copies of Part II, Vol. II, of the Medical and Surgical History of the War of the Rebellion was completed, under the supervision of Assistant Surgeon G. A. Otis; one hundred and thirty-five drawings on wood, and one hundred and thirty six engravings, were made for the Third Surgical Volume of the Medical and Surgical History of the War, and fifty pages of that volume were put in type, of which twenty-one pages were stereotyped.

A Report on the Transport of Sick and Wounded by Pack Animals—thirty-two pages, quarto—was prepared and printed under the same editorial supervision.

## NOTES AND COMMENTS.

### Bills for 1878.

With this and the next number we inclose to those subscribers who have not yet remitted, their bills for the current year. We ask them to give them prompt attention, and forward the amount called for. In case that any explanation or correction is desired, we shall be happy to make it.

As in some instances it may be more convenient to the subscriber to remit at a later date, we shall, with all such, be most willing to make an arrangement to that effect.

We particularly ask that all who receive a bill will favor us promptly with a response of some kind.

### The Iodide of Starch.

Professor Ranieri Bellini has made a communication to the Medico-Physical Society of Florence, on the iodide of starch, which MM. Bouchardat and Quesneville were the first to introduce into therapeutics, and frequently employed in cases which required an active alterative medication, when the stomach refused to tolerate iodine in any other form. The iodide of starch is a chemical antidote which is specially appropriate to poisoning by sulphur,



by the alkaline or earthy sulphurets, by caustic alkalies, ammonia, or any of the alkaloids. It is also an eliminating agent, very useful in the treatment of long-standing metallic poisonings, especially those resulting from lead or mercury. Dr. Bellini advises that the patient should always be made to vomit soon after the administration of the antidote, to rid him of the chemical products which result from the decomposition of the toxic agent, which in their turn might likewise become decomposed.

#### Alimentation in Surgical Accidents and Diseases.

Dr. Frank H. Hamilton read a paper, at a meeting of the New York Academy of Medicine, on the above subject, in which he urged that alimentation should be more studied in the treatment of surgical cases than it was. He said that in hospitals there was a tendency to cut off extra diet, though liquors and medicines were given freely. He suggested, also, that it would be a wise plan to attach a diet-kitchen to dispensaries.

#### A New Theory of the Nature of Water.

M. Maiche, in *Les Mondes*, propounds the theory, reached after numerous experiments, that water is simply hydrogen *plus* electricity, or oxygen *minus* electricity; or, in other words, that normal electrified hydrogen constitutes water, and that normal diselectrified oxygen produces the same; or that hydrogen, oxygen and water are precisely the same, differing only in degree of electrification.

#### The Treatment of Habitual Drunkards.

Dr. Moore, medical officer of the County Antrim Prison, Ireland, has recently published a pamphlet in relation to the treatment of habitual inebriates. In the case of confirmed drunkards, of whom the vast majority of prisoners consists, he suggests that a person once committed should not be allowed at large again until the habit of intemperance is cured. Short terms of imprisonment do not allow the effects of the drink to be eliminated from the system, and liberation from confinement destroys any moral reformation which may have begun. Dr. Moore argues that habitual drunkards should be committed, like prisoners under remand, the remand to be for a period of not less than three months; and after being discharged they should be liable to be called upon periodically to prove that they are conducting

themselves in a quiet and sober manner, the evidence of this state of things to consist of a certificate from a clergyman, a physician, or three householders; the supervision to last for twelve months.

#### On the Treatment of Fractures with Cotton-Wool Dressings.

Dr. Monton, of Paris, has, in Prof. Broca's wards, carried out a series of experiments which have demonstrated that compression made with cotton wool dressings lessens the power of muscular contraction in a very remarkable manner, and for that reason it is a useful auxiliary in the reduction of fractures. The use of this bandage also obviates the complications which may supervene in compound fractures. Finally, this means allows the delay of the serious operations rendered necessary by wounds.

Dr. Monton's conclusions are as follows: 1. Fractures may be reduced, and kept in place by cotton-wool dressing. 2. Cotton-wool dressing is exclusively indicated in fractures with communicating wounds, in hospitals and all other localities where the air is vitiated by overcrowding. 3. The same dressing gives the power of delaying operations actually contra-indicated by the state of the patient, with advantage both to him and to the surgeon.

#### The Difference Between Hard and Soft Chanores.

The general tendency of the latest research seems toward the doctrine of the unity of the syphilitic virus. Some recent German writers, however, especially Drs. Auspitz and Unna, claim that there are essential histological differences between the soft and hard chanores. The characters distinctive of the latter are hardness and chemical change in the bundles of connective tissue, and a peculiar development of the epidermis. The epidermis grows downward in processes which send out projections horizontally to the skin, and these are subsequently snared and isolated by the growing connective tissue. Masses of granulation-cells penetrate to the horny layer of the epidermis, and are also found in the cutis, bounded by tracts of epidermis. The form of the sclerosis depends on the arrangement of the blood-vessels, the process taking its origin from the adventitia. The coats of the blood-vessels are markedly affected, those of the lymphatic vessels to a less degree.

## CORRESPONDENCE.

## Unusual Action of Anæsthetics.

ED. MED. AND SURG. REPORTER:—

Following up the editorial in your journal of December 22d, 1877, on "Inquiries Concerning Anæsthetics," I think it well to accumulate all evidences of peculiar and interesting experiences in the administration of chloroform and ether (particularly those of a medico-legal character), for the protection of our profession from false criminal prosecutions, that have occurred in this country as well as in England, and, under the present want of knowledge in this relation by the members of the bar, are liable to occur at any time. A counselor-at-law, to give good advice, must have some facts, where there is no special law in relation to the subject upon which he can reason and form therefrom an honest opinion. Not having any accumulation of cases upon this subject, and knowing no facts in relation thereto, an attorney may, at the suggestion of a person, undertake the prosecution of an innocent party, which he would not so advise if such facts were laid before him showing that his client may be suffering under a false impression, and there was no cause for an action at law. With this idea in view I would call upon the profession to make public any interesting cases that have come to their personal knowledge, so that a compilation of the same can be made, for use by attorneys-at-law and the courts in general.

During the course of a number of years of study in Europe, I was present and assisted in the administration of chloroform very many times, in the various clinics and hospitals; and since my return home to this city, I have had considerable experience with chloroform, ether, and bichloride of methylene, as anæsthetics, in my hospital clinics, as well as in private practice; the following cases have come under my observation, all of which I have no doubt can be authenticated by the experience of others as soon as the interest in compiling such cases is aroused.

In relating the cases I will present, first, those of peculiar hallucinations; second, as to the retention of consciousness during the operation without feeling pain; third, as to anæsthesia while asleep, without awakening.

While I was attending Prof. von Graefe's clinic, in Berlin, a young lady of about 19 years came in, for the operation of neurotomy of the supra-orbital nerve. It was necessary to anæsthetize her, chloroform being used. During which act, in the presence of the class, she passed through all the actions and emotions of coition. Dr. von Graefe called attention to this, as one of the effects, at times, of inhaling chloroform, and advised the necessity of having several present when chloroform was administered to the opposite sex.

In my clinic in the Wills Eye Hospital, in 1874, a female of seventeen years of age came

to me to be operated on for strabismus convergence. She wished to be etherized, so as to prevent her feeling any pain. During the administration of the anæsthetic by the house surgeon, in the presence of several visiting students and physicians, as well as the regular clinic assistants, she, after a few minutes' inhalation, began talking in the most lascivious manner, accompanied with all the actions and emotions of sexual intercourse; and when coming out from under the deep anæsthesia, after the operation, the same hallucination and actions possessed her. When free from its influence she claimed that one of the assistants had had sexual intercourse with her. This idea was given up, however, after being assured that such was not the case, and of the number present at the operation. Some one must have mentioned the whole or part of the affair to her, for on her appearance at the next clinic day she very modestly apologized to me for her actions, saying, "that she could not help it, as she knew nothing at the time."

In the spring of 1876 I was obliged to etherize a young lady, so that I could make the operation of tearing loose posterior synechia, and during the inhalation, which was administered by my friend, Dr. Frank Fisher, her eyes became uncovered for a moment, in which time she opened them and looked staringly and frightened at me, as I sat by her side holding the pulse. She struggled to get away, and attempted to scream. Her eyes were at once covered, and the ether pushed to complete anæsthesia. After coming out from under its influence, she told the young lady friend with whom she was staying, and who was present at the operation, that "I had turned into a wild cat; she was positive of it." For ten days she was so impressed with this delusion that she would not look at me, and it was with difficulty that I could treat the eye.

In relation to the second question, "Can there be retention of consciousness during the operation, without feeling pain?" the following two cases will show that such can be.

In the summer of 1863, while I was assisting Dr. Hensey in the surgical wards of the Citizen's Hospital (Bürgerpital), in Berne, Switzerland, a case of amputation of the leg at the lower third of the femur was made on a gentleman of that city, in which it was necessary to administer an anæsthetic. After inhaling chloroform for a few minutes he lost all feeling, but continued to converse with Dr. Hensey, and told him to go on with the operation, but before doing so they should prop him up, so that he could see the whole affair. He looked at the operation very quietly, and denied feeling the least pain, nor did he show in the least that he experienced any.

In April, 1871, in my clinic in the Philadelphia Eye and Ear Infirmary, I made an operation for shrinkage of a staphylomatous eyeball, on a lady of thirty-five years of age, who, after inhaling a mixture of chloroform and ether a few minutes, lost all feeling, but not conscious-

ness, and the operation was made without the least sensation of pain, as assured me by the patient, who remained perfectly quiet, and answered promptly every question that I put to her. The anæsthetic was administered by my assistants, Drs. J. W. Milliock; D. C. Lloyd and W. F. Church, in the presence of several students who were attending my clinic and lectures at the time.

To the third question, "Can one be anæsthetized during sleep without awakening?" the following will show:—

July 26th, 1876, I was called to Lebanon, Pa., to enucleate the eyeball of a boy, who had received, twenty-three days previously, some shot in his face, from a gun, one of which had penetrated the eye, destroying it. When I arrived, his father said that his son had just fallen asleep a few minutes before, and asked if he should awaken him. I at once proposed to Drs. Light, Lineaweaver and Gilford, of that place, who were present, that we should not awaken him, but try to etherize him while asleep. We went up quietly into the room; Dr. Light took the towel, on which ether had been poured, and approached him gently and slowly, I renewing the ether from time to time, until the cloth was applied immediately over the face, and thus he was put completely under the influence of the anæsthetic without his waking up; he making only a slight roll over from one side to the other. He was then carried out into the adjoining room, in which the operation was to be made, laid on a settee arranged for that purpose, and the eyeball removed. He did not wake up from the time he went to sleep on his mother's bed, before I arrived, until after the operation was completely finished; and then he came to himself with the remark, "Let my eye alone."

Hoping that you may be the means of drawing this needed information together as a safeguard for the future, I remain, yours truly,

P. D. KEYSER, M.D.

1630 Arch street, January 10th, 1878.

#### Treatment of Diphtheria.

ED. MED. AND SURG. REPORTER:—

Our village contains less than six hundred inhabitants. Has long been noted for its healthfulness. About the middle of last September it was visited by an epidemic of diphtheria, since which time there have been sixteen deaths from the disease. All the deaths were between the ages of two and fifteen years. I have treated thirty cases in all, some of marked severity. I had one death only; it in a family of fourteen members, five of whom were subjects of the disease, crowded into a room twelve by eighteen feet, in squalor, filth and ignorance. This case had epistaxis till he nearly bled to death, then laryngitis, with exudation, till his life was despaired of; yet he lived two weeks after all traces of the diphtheritic membrane had disappeared. I feel satisfied that, had he had proper hygiene and suitable nursing and

food, he would have recovered. I used in all but my first case the sulpho-carbolate of sodium, as recommended by Dr. Anthony, of Providence, R. I. I use it in doses from five to thirty grains, in an aromatic syrup. I also use freely a saturated solution of chlor. pot., beef tea and milk. No swabbing or gargle; tonics when indicated. I have noticed an entire absence of fetor in my cases, which is in marked contrast with cases treated by others, who have used quinia, tr. ferri chlor., pot. chlor., etc. I have not seen the least bad effect from its use in large doses. I am beginning to have faith in it as a prophylactic, and think it is worthy of further trial.

D. A. PHILIPS, M.D.

Linesville, Pa., January 14th, 1878.

#### NEWS AND MISCELLANY.

CORRECTION.—On p. 58, line 3 from foot of first column, for *nervous* read *venous*.

#### Effect of Music on Mania.

Some curious experiments have lately been made in the Randall's Island Asylum, New York city. Their object was to determine, if possible, the relative and specific effects of rhythm, melody, and harmony upon patients suffering with melancholia and acute mania, and to note the emotional influence and therapeutic results (if any) of the different modes and various kinds of music, when performed under favorable circumstances, to individuals and groups selected from the large number of insane now under treatment on the island. About fourteen hundred female patients were assembled in the entertainment hall, and subjected to a continuous strain of piano music for half an hour. It was observable that the general effect was to raise the pulse and make the patients restless. A prevalent desire to keep time with the dance music was noticeable. Rhythm they were all susceptible to, and its effect was stimulating. Mere melody of an uncertain tempo was without any effect, except in those individual cases where the force of association was still operative. During the performance of a waltz, it was with the greatest difficulty that the keepers could keep the patients in their seats; and even when thus confined, the greater number kept time by drumming on the seats with their hands, wagging their heads, or shuffling their feet. In one case of chronic melancholia, the performance of "Home, Sweet Home," invariably brought the patient to her knees, where she began to recite the "Lord's Prayer" in an apparent ecstasy of devotion. In another case of acute mania, the dance music raised her pulse from 78 to 106, without the patient exhibiting any other signs of excitation than the involuntary twitching of her facial muscles. In the worst cases, cantabile music seemed to have much the same soothing effect that it has upon certain animals. They were disposed to

lie comfortably down and go to sleep under it. In nearly every instance the effects of pronounced rhythm were involuntary, the movements of the limbs and facial muscles being attributed to reflex action.

#### A Heroic Deed.

A wonderful example of self-sacrifice is reported of one of the Sisters of the Order of Trojes. She was in charge of some convalescent children for a walk, when they were assailed by a sheep-dog in the last stage of rabies. Seeing the danger she rushed between the infuriated creature and her charge. She was severely bitten, and the dog in its fury turned upon the children. The poor little things were too terrified to run away, but the true *sœur de charité* threw herself on the mad beast, and for ten minutes rolled over with it, having thrust her fist into its mouth. Some peasants came at last, beat it off, and killed it. The Sister received fifteen wounds on her hands, her arms were lacerated, and an important artery was wounded. Such skillful attention was bestowed that for a short time after her return to Paris there was hope of recovery; but in a few weeks the dreaded symptoms made their appearance, and the nurse, whose heroism had saved five children, died in agony.

#### Personal.

—Dr. Vanderbeck informs us that the success of the *Druggist and Chemist* has been such as to permit an enlargement of the journal at once. The February number will contain a number of additional pages of reading matter. An interesting feature will be an offer of a prize to the medical or pharmaceutical undergraduate who answers best certain questions asked.

—The daily *Times*, of this city, has the following: Dr. Mary Putnam-Jacobi, who received the Boylston medical prize at Cambridge—the judges being under the impression that they were giving it to a man—is honored by a reception in Boston. The Boylston prize was good enough in its way, but the Boston reception settles definitely her intellectual status.

—Dr. George T. Barker, a well-known dentist of this city, a professor in the Pennsylvania College of Dental Surgery, and formerly one of the editors of the *Dental Times*, died on Thursday, January 10th, aged 42 years. His death was caused by typhoid fever.

—Dr. C. W. Bernacki, of New York City, includes this journal in his printed list of those with which he is prepared to make advertising contracts. We distinctly state that we shall not receive any contract from or through him, and he is not authorized to receive subscriptions or transact any kind of business for us.

—Dr. T. D. Crothers has delivered, by request, several lectures before the Faculty and students of Yale College, on alcohol and the diseases which arise from it.

#### Items.

—The Georgia Legislature is considering a law prohibiting the selling of tobacco to minors.

—The life saving service shows a saving of 1451 lives during the year, and property worth \$1,713,647.

—A correspondent of the *Daily News*, who left Erzeroum just before its investment, telegraphs that the town is now little better than a huge hospital. About a hundred soldiers die daily, and two or three are frozen to death every night. Typhus fever is raging.

—At the seventeenth annual meeting of the contributors to the Woman's Hospital, this city, held last week, Mrs. M. K. Williamson presiding, the resident physician's report showed that during the year 268 patients were treated in the hospital and 5836 in the dispensary and at their homes, and that 14,350 visits were made by patients to the dispensary.

#### QUERIES AND REPLIES.

Dr. C. M. M., of Ohio.—“Can any of your readers recommend a good prescription for quartan intermittent?”

Dr. J. W. H., of West Va.—“Would the nitrite of amyl be contraindicated in a case of inveterate headache following suspended epilepsy, neuritis descendens, and complete amaurosis?”

Reply.—We should think not.

#### MARRIAGES.

ADGATE—FISK.—In East Hardwick, on December 20th, Dr. L. W. Adgate, of East Hardwick, and Mary Fisk, of New Jersey.

EDGAR—MILLER.—On December 20th, 1877, at the residence of the bride's father, at Cross Roads, Pa., by Rev. J. M'Gaughey, Joseph D. Edgar, M.D., of Railroad, Pa., and Lizzie E. Miller, of Cross Roads, Pa.

GOLDSBOROUGH—WINTER.—On January 9th, 1878, in Christ Church, Easton, Maryland, by Rev. Robert Wilson, Dr. Charles B. Goldsborough, of the United States Marine Hospital Service, and Eleanor G., daughter of the late Rev. John Winter.

MOORE—TRAINER.—On December 31st, 1877, at the bride's home, in Strattonville, by Rev. O. A. Elliott, Dr. O. G. Moore, of Edenburg, and Miss Emma J. Trainer, of Strattonville, both of Clarion county, Pa.

#### DEATHS.

BARKER.—In this city, on the 10th instant, Dr. George T. Barker, in the forty-third year of his age.

GUTHRIE.—At Washington, D. C., on Friday morning, December 28th, 1877, Dr. C. B. Guthrie, aged sixty-three years.

JOHNSON.—In Chester, Delaware county, on the 30th ult., Joseph H. Johnson, M.D., aged twenty-eight years, formerly of Bucks county.

LITTLE.—In Concord, N. H., on December 31st, John W. Little, M.D., D.D.S., aged fifty-nine years, eight months and fourteen days.

MAXWELL.—In this city, on the 9th instant, of typhoid pneumonia, J. Gordon Maxwell, M.D., in the thirty-eighth year of his age.

WILLIAMS.—In Ellcottville, New York, on December 7th, 1877, Dr. Thomas J. Williams, aged seventy-five years.